

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown			c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hospital				d. STREET ADDRESS Quaker Neck RFD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Daniel Barrett				4. DATE OF DEATH Month Day Year Sept. 18, 1961			
5. SEX male		6. COLOR OR RACE colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 2/4/1891	
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Farm and various		11. BIRTHPLACE (State or foreign country) Kent Co. Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Daniel Barrett (218)				14. MOTHER'S MAIDEN NAME Susie Graves			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-30-2222		17. INFORMANT Address RFD Rosa Miller Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia 293X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 16, 1961 to Sept. 18, 1961 that (I) (we) last saw the deceased alive on Sept. 17, 1961 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE <i>E. Kester</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/18/61	
22c. PHYSICIAN'S NAME (Type) Eugene Kester				22d. ADDRESS Rock Hall, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/21/61		23c. NAME OF CEMETERY OR CREMATORY Pomona Cemetery near Chestertown, Md.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Benjamin O. Day</i>				ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE SEP 22 '61	
				25b. REGISTRAR'S SIGNATURE <i>Arthur L. Finner</i>			

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MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10300

CERTIFICATE OF DEATH

Reg. Dist. No. 10295

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chestertown c. LENGTH OF STAY IN 1b short d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Great Oak Yacht Club		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna b. COUNTY Haverford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Haverford d. STREET ADDRESS Taylor Lane & Harvest Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ralph B. Bencker		4. DATE OF DEATH Sept. 3, 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24, 1882
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min.	11. IF UNDER 24 HRS. Months 78 Days 78 Hours 78 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Architect		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Don't know		14. MOTHER'S MAIDEN NAME Mary Bowden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. yes	
17. INFORMANT Mrs. Ralph Bencker (wife)		Address Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) arteriosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last, (c) arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 minutes year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 3, 1961 , to Sept 3, 1961 , that I last saw the deceased alive on 19 , and that death occurred at 5:55 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas J. Solon		ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 9/3/61	
PHYSICIAN'S NAME (Type) Thomas J. Solon			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 7, 1961	22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cem.	22d. LOCATION (City, town, or county) (State) Philadelphia, Penna.
23. FUNERAL DIRECTOR'S SIGNATURE Willis Wells ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR SEP 6 '61	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10301

10296

1. PLACE OF DEATH a. COUNTY <u>Kent</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, state and county of admission) a. STATE <u>md</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>	
c. LENGTH OF STAY IN 1b <u>6 days</u>		d. STREET ADDRESS <u>17 X-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kent & Queen Anne's Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Wendell</u> First Middle Last		4. DATE OF DEATH Month Day Year <u>September 9 1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 9, 1961</u>
9. AGE (In years last birthday) <u>6</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Kent Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wendell Bordley</u>		14. MOTHER'S MAIDEN NAME <u>Adelena Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mother</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity - No digestive</u> <u>774X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>function</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>7 days</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 7</u> 19 <u>61</u> to <u>Sept 9</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Sept 7</u> 19 <u>61</u> , and that death occurred at <u>2:15</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>C. R. Bayton</u>		22b. DATE <u>Sept 9, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. R. Bayton</u>		22d. ADDRESS <u>Centreville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/10/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Burrisville Cem.</u>		23d. LOCATION (City, town or county) (State) <u>nr. Centreville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Genneth Waley</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 13 '61</u>	
ADDRESS <u>Chestertown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10302

CERTIFICATE OF DEATH

10297

1. PLACE OF DEATH a. COUNTY <i>Kent</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Kent</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rock Hall</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>X Rock Hall</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Hawthorne Rd.</i>		d. STREET ADDRESS <i>1 Hawthorne Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>Ina Beck Downey</i>		4. DATE OF DEATH Month <i>Sept</i> Day <i>22</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 12, 1894</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	9. AGE (In years last birthday) <i>67 yrs.</i>
11. BIRTHPLACE (County & State, or foreign country) <i>Rock Hall Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Lemuel Beck</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Watson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-10-2014</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardio Vascular</i> DUE TO (c) <i>Emphysema</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 1</i> 19 <i>52</i> to <i>Sept 21</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>Sept 21</i> 19 <i>61</i> , and that death occurred at <i>2:45</i> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Norbert C Nitsch</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>NORBERT-C-NITSCH</i>		22d. ADDRESS <i>ROCK-HALL MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>9/24/61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Wesley Chapel Am.</i>	23d. LOCATION (City, town or county) (State) <i>Rock Hall Maryland</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Marvin V William Chesapeake Md.</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 25 '61</i>	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10303

CERTIFICATE OF DEATH

Reg. Dis. No. 10298

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN 1b adult life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent St.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Chestertown d. STREET ADDRESS 1 Kent St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Otis Middle Houston Last Flowers		4. DATE OF DEATH Month Sept. Day 6 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1911
9. AGE (In years last birthday) 50		10. IF UNDER 1 YEAR Months 11 Days 10 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk at A.P. Food Stores		10b. KIND OF BUSINESS OR INDUSTRY Dorchester Co. Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter D. Flowers		14. MOTHER'S MAIDEN NAME Julia Adams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-14-4000	
17. INFORMANT Lillie Mae Flowers		Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary insufficiency DUE TO 241X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic obstructive pulmonary emphysema DUE TO Asthma (c) 30 years		INTERVAL BETWEEN ONSET AND DEATH 2 hours 10 years 30 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1955 , to September 6, 1961 that I last saw the deceased alive on September 6, 1961 , and that death occurred at 9 p. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 9/7/61			
ACTUAL SIGNATURE A. C. Dick M.D.		DATE SIGNED 9/7/61	
PHYSICIAN'S NAME (Type) A. C. Dick		ADDRESS Chestertown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/9/61	
22c. NAME OF CEMETERY OR CREMATORY Chestertown, Md.		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR SEP 11 '61 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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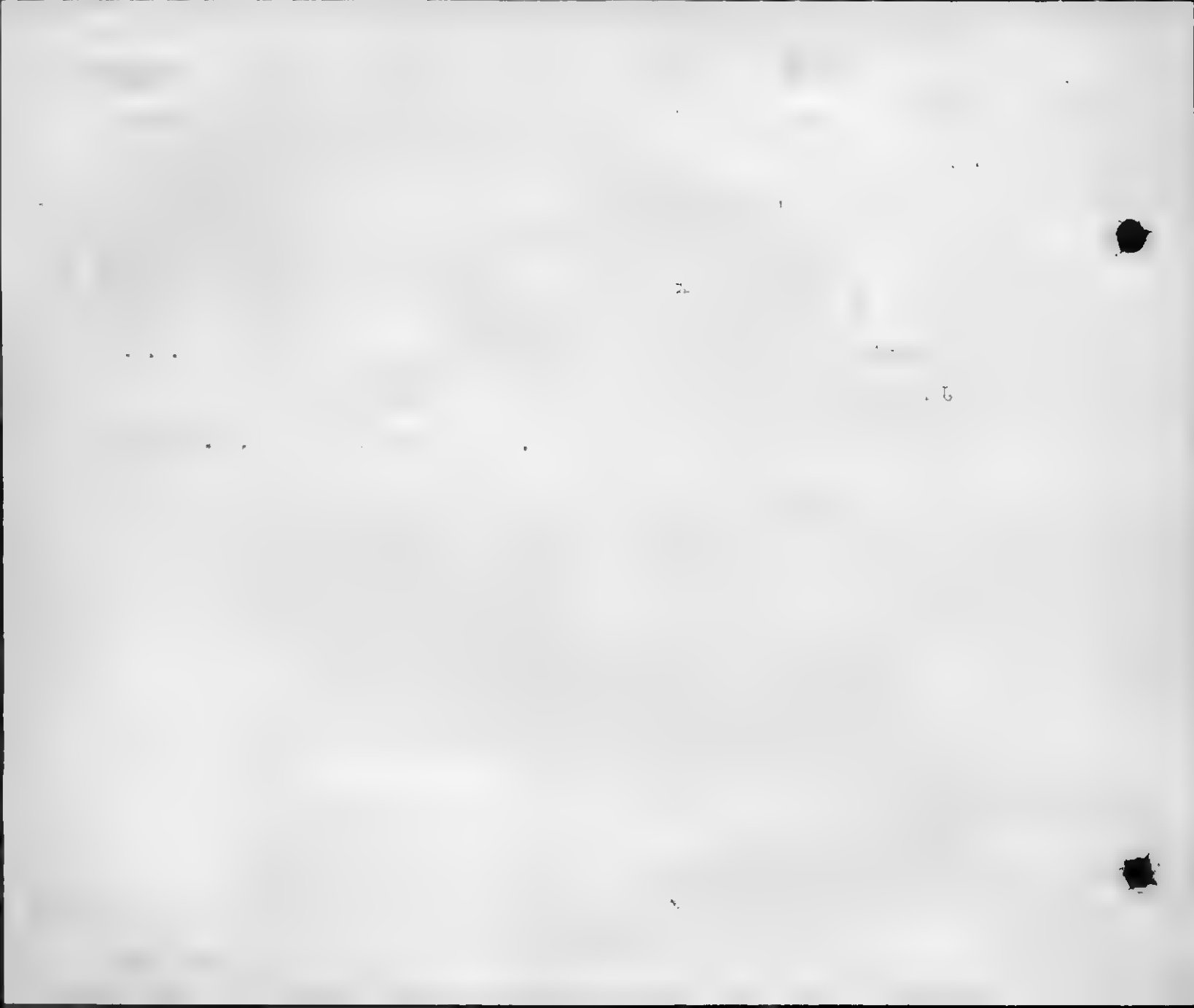
10304

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10299

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN 1b 15 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kent & Queen Anne's Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rock Hall d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Agnes Middle Quail Last Francis		4. DATE OF DEATH Month 9 Day 21 Year 1961	
5. SEX Female 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/10/91 9. AGE (In years last birthday) 70 yrs. 10. UNDER 1 YEAR Months Days 11. UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
13. FATHER'S NAME John Lewis		14. MOTHER'S MAIDEN NAME Agnes Quail	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. June Stenger, Rock Hall, Md. (daughter)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cholemia 58110 DUE TO Conditions, if any, which gave rise to immediate cause (b) Carbonyl of iron (c), stating the underlying cause last. DUE TO		INTERVAL BETWEEN ONSET AND DEATH 7 days 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid arthritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-1-1959 to 9-21-1961 , that (I) (we) last saw the deceased alive on 9-21-1961 , and that death occurred at 149 PM , from the causes and on the date stated above.			
22a. SIGNATURE A.C. Dick		22b. DATE SIGNED 9-22-61	
22c. PHYSICIAN'S NAME (Type) A.C. Dick		22d. ADDRESS Chestertown	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/24/61	
23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel		23d. LOCATION (City, town or county) (State) Rock Hall Ind.	
24. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane		25a. REC'D BY REGISTRAR SEP 27 '61	
24. ADDRESS Chick Hill Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10305 CERTIFICATE OF DEATH 10300											
1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>KENT.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN.</u> length of STAY in life <u>37</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kent & Queen Anne's</u>						STREET ADDRESS					
3. NAME OF DECEASED (Type or print) <u>HARRALISA MARIA JOHNSON</u>						4. DATE OF DEATH Month <u>SEPT.</u> Day <u>20</u> Year <u>1961</u>					
5. SEX <u>FE.</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-18-61</u>		9. AGE (in years last birthday) <u>3</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>						11b. KIND OF BUSINESS OR INDUSTRY <u>Kent Co. Maryland</u>					
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>						13. FATHER'S NAME <u>Allen JOHNSON</u>					
14. MOTHER'S MAIDEN NAME <u>MOORE</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>					
16. SOCIAL SECURITY NO. <u>none</u>						17. INFORMANT <u>Hospital Records</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable subdural hemorrhage</u> 760.0 DUE TO (b) <u>Some what traumatic labor & delivery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/18/61</u> to <u>9/20/61</u> , that (I) (we) last saw the deceased alive on <u>9/20/61</u> , and that death occurred at <u>5:22</u> M, from the causes and on the date stated above											
22a. SIGNATURE <u>Robert W. Farr</u>						22b. DATE SIGNED <u>9/20/61</u>		22c. PHYSICIAN'S NAME (Type) <u>ROBERT W. FARR</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						23b. DATE THEREOF <u>9/21/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pomona Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Nr. Chestertown, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Farr</u>						25a. REC'D BY REGISTRAR <u>SEP 22 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

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Journal of Management Studies, 19(6), 701-718.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

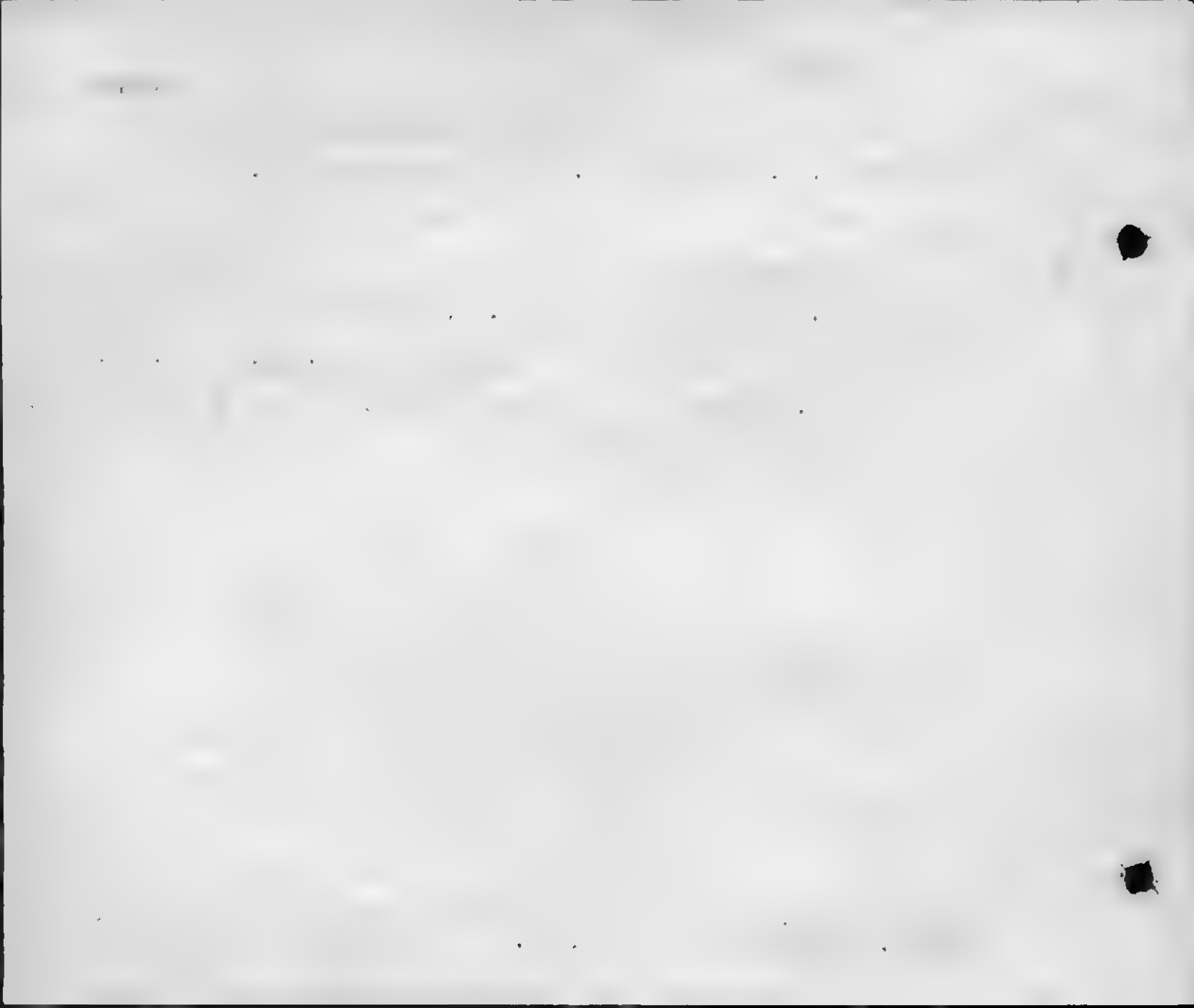
CERTIFICATE OF DEATH

10306

10301

| | | | |
|---|------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
e. COUNTY Kent
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Chestertown R. D. 3
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Quaker Neck | | 2. USUAL RESIDENCE (Where deceased lived, if institution; if not, give address) (If outside of corporate limits, write RURAL and give nearest town)
a. STATE Maryland
b. COUNTY Kent
c. CITY OR TOWN Chestertown R. D. 3
d. STREET ADDRESS Quaker Neck | |
| 3. NAME OF DECEASED (Type or print) William Greensborough Johnson | | 4. DATE OF DEATH September 11 1961 | |
| 5. SEX Male | 6. COLOR OR RACE Col. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 2, 1918 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer | | 11. PLACE, County & State or foreign country Queen Anne Co. Md. | |
| 13. FATHER'S NAME David Thos. Johnson | | 14. MOTHER'S MAIDEN NAME Bessie Goldsborough | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 314-18-4191 | |
| 17. INFORMANT Mrs. Mary G. Johnson | | Address Chestertown R.D. 3 Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e) Coronary Thrombosis
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerosis
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH 10 minutes
? | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work et work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Sept 7, 1961 , to Sept 11, 1961 , that (I) (we) last saw the deceased alive on Sept 11, 1961 , and that death occurred at 9 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Thomas J. Solow | | 22b. DATE SIGNED 9/12/61 | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Sept. 14/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Uniontown Cemetery | | 23d. LOCATION (City, town or county) (State) Near Church Hill, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Harmon V. Williams | | 25a. REC'D BY REGISTRAR SEP 15 61 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Hume | | DATE | |

VR A15 (4)
15M 9/60



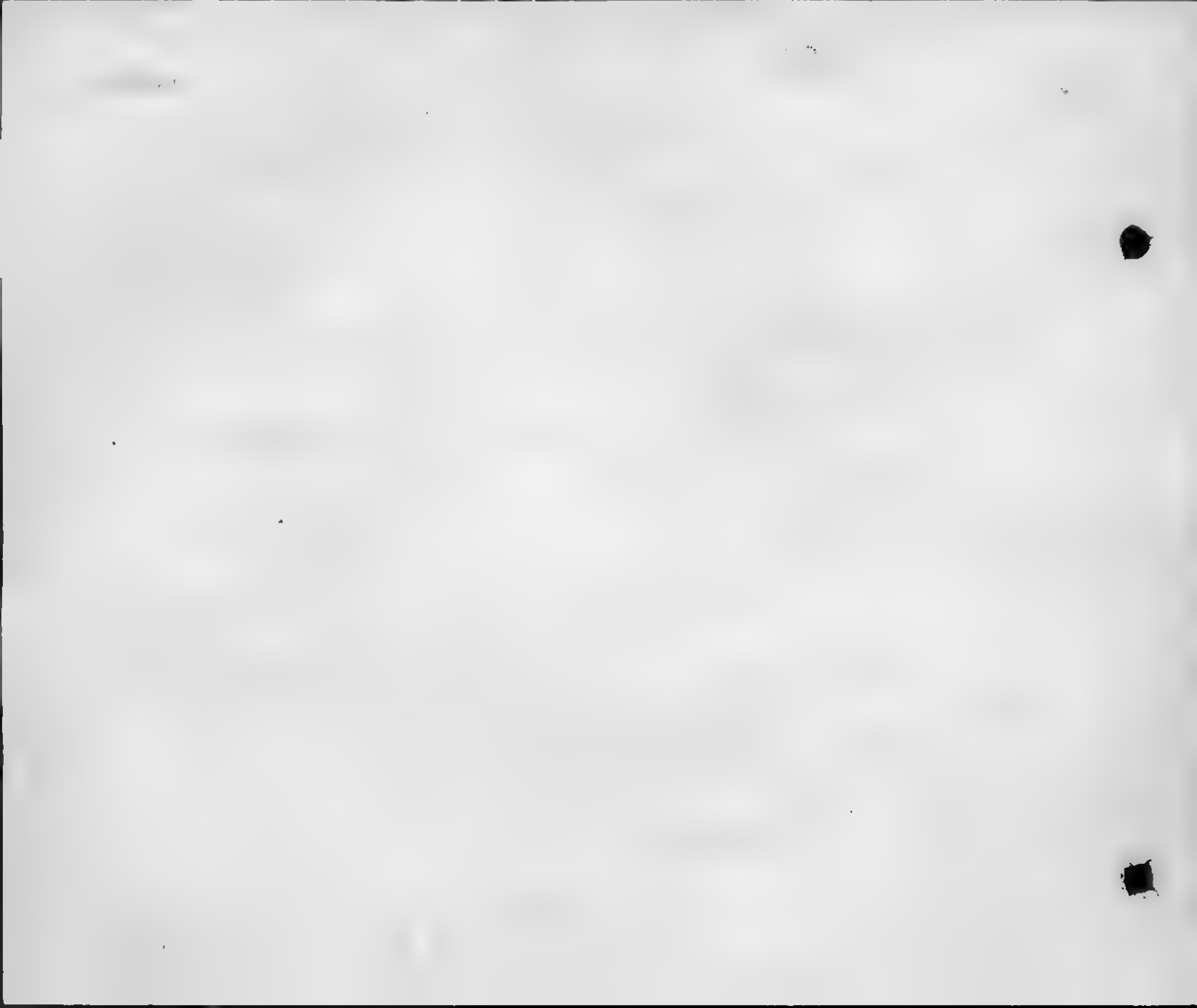
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

13701

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|---------------------------|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Kent | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
a. STATE Maryland b. COUNTY Kent | | | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Rural Chestertown | | c. LENGTH OF STAY in lb
lifetime | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Chestertown | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
RFD - Georgetown Section | | d. STREET ADDRESS
RFD # 2 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
Ida Jones | | 4. DATE OF DEATH
Sept. 23, 1961 | | 9. AGE (In years, months, days, hours, minutes)
89 | | | | | | | |
| 5. SEX
female | | 6. COLOR OR RACE
colored | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Feb. 26, 1872 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Kent Co. Maryland | | 11. BIRTHPLACE (County & State, or foreign country)
USA | | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 13. FATHER'S NAME
Samuel Cotton | | 14. MOTHER'S MAIDEN NAME
Sarah Ward (Cotton) | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) none | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Ardena Groce RFD Chestertown, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Senility
DUE TO
Conditions, if any, which gave rise to immediate cause (b)
[a], stating the underlying cause last, (c)
194X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY
Hour a.m. 19
p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
March 1961 | | 20g. (County)
Sept. 23, 1961 | | 20h. (State)
4P | |
| 21. I certify that (I) (this hospital) attended the deceased from March 1961 to Sept. 23, 1961 , that (I) (we) last saw the deceased alive on Sept. 22, 1961 , and that death occurred at 4P , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Eugene Keater | | 22b. DATE
9/24/61 | | 22c. PHYSICIAN'S NAME (Type)
Eugene Keater | | | | | | | |
| 22d. ADDRESS
Rock Hall, Maryland | | 22e. REC'D BY REGISTRAR
SEP 27 '61 | | | | | | | | | |
| 22f. REGISTRAR'S SIGNATURE
Arthur S. Kline | | 22g. REGISTRAR'S NAME
Arthur S. Kline | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Sept. 27, 1961 | | 23c. NAME OF CEMETERY OR CREMATORY
Georgetown Cem. | | 23d. LOCATION (City, town or county)
near Chestertown, Md. | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Kenneth Weebly | | 24a. ADDRESS
Chestertown, Md. | | | | | | | | | |



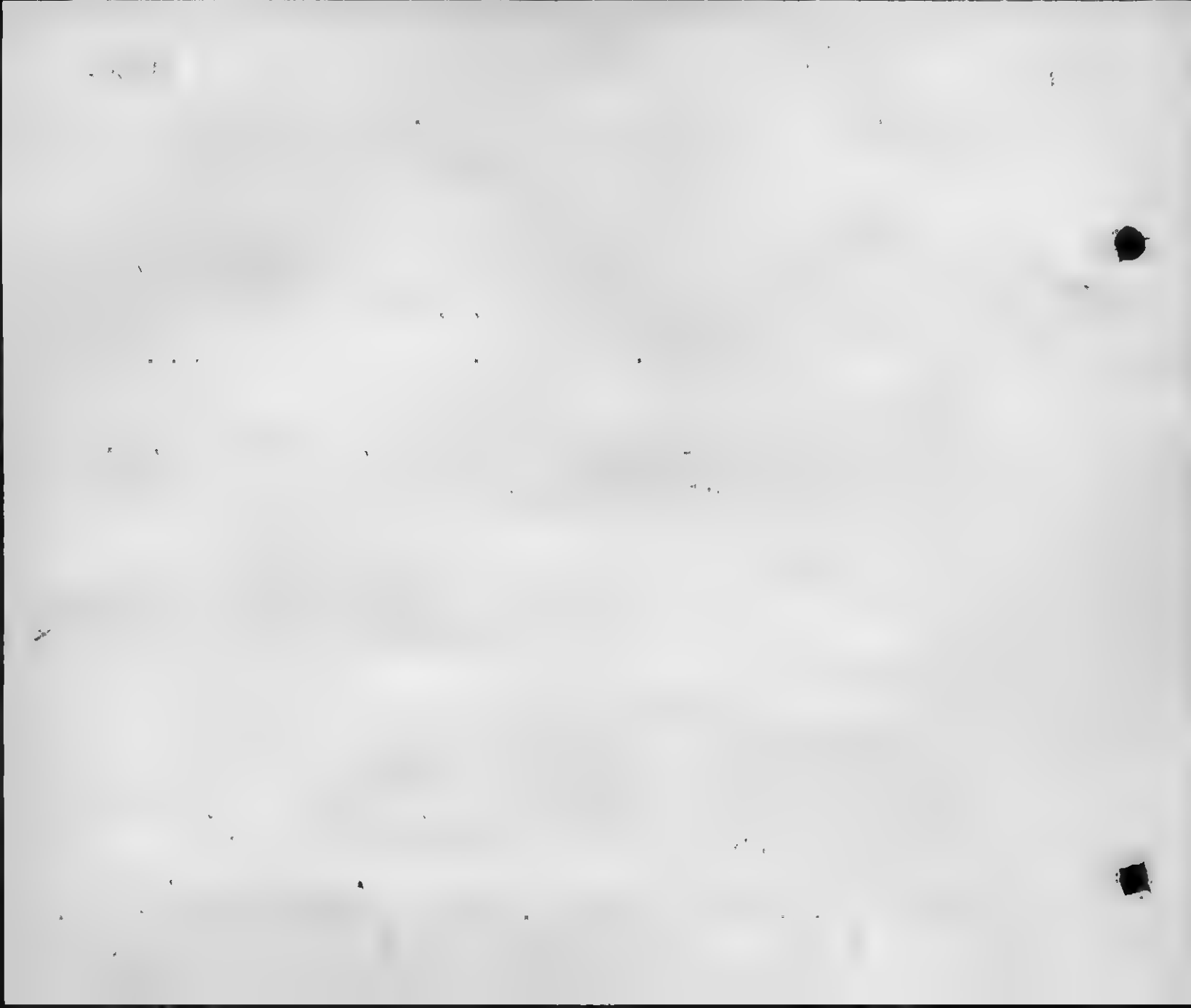
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician and correctly filled in by the funeral director. After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M 10308 Item 8 Film G-297 30/6/61 10303

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | |
|--|------------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Kent | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Md. b. COUNTY Kent | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Millington | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Millington | |
| c. LENGTH OF STAY IN 1b | | d. STREET ADDRESS | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | |
| 3. NAME OF DECEASED
(Type or print)
Alphonso | | 4. DATE OF DEATH
Month September Day 29 Year 1961 | |
| 5. SEX
Male | 6. COLOR OR RACE
Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April, 1, 1886 |
| 9. AGE (In years) 71 yrs. | | 10. C. T. ZEN OF WHAT COUNTRY?
U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farm Labor | | 10b. KIND OF BUSINESS OR INDUSTRY
Farming. | |
| 11. BIRTHPLACE (County & State, or foreign country)
Md. | | 12. C. T. ZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
No Record | | 14. MOTHER'S MAIDEN NAME
No Record | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No Record | | 16. SOCIAL SECURITY NO.
169-12-2095 | |
| 17. INFORMANT
Estella Ricketts, | | Address
Millington, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lobar Pneumonia | | | |
| 490X DUE TO | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Sept 29, 61 to Sept 29, 61 , that (I) (we) last saw the deceased alive on Sept 29, 61 , and that death occurred at 4:30 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
H. H. Hamilton | | 22b. DATE
Sept 30, 61 | |
| 22c. PHYSICIAN'S NAME (Type)
H. H. HAMILTON | | 22d. ADDRESS
Millington, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Oct. 2, 1961 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Millington Col. Cemetery | | 23d. LOCATION (City, town or county) (State)
Millington, Kent Co; Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Edward Hollows, | | 25a. REC'D BY REGISTRAR
OCT 3 '61 | |
| 25b. REGISTRAR'S SIGNATURE
Charles L. Thomas | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

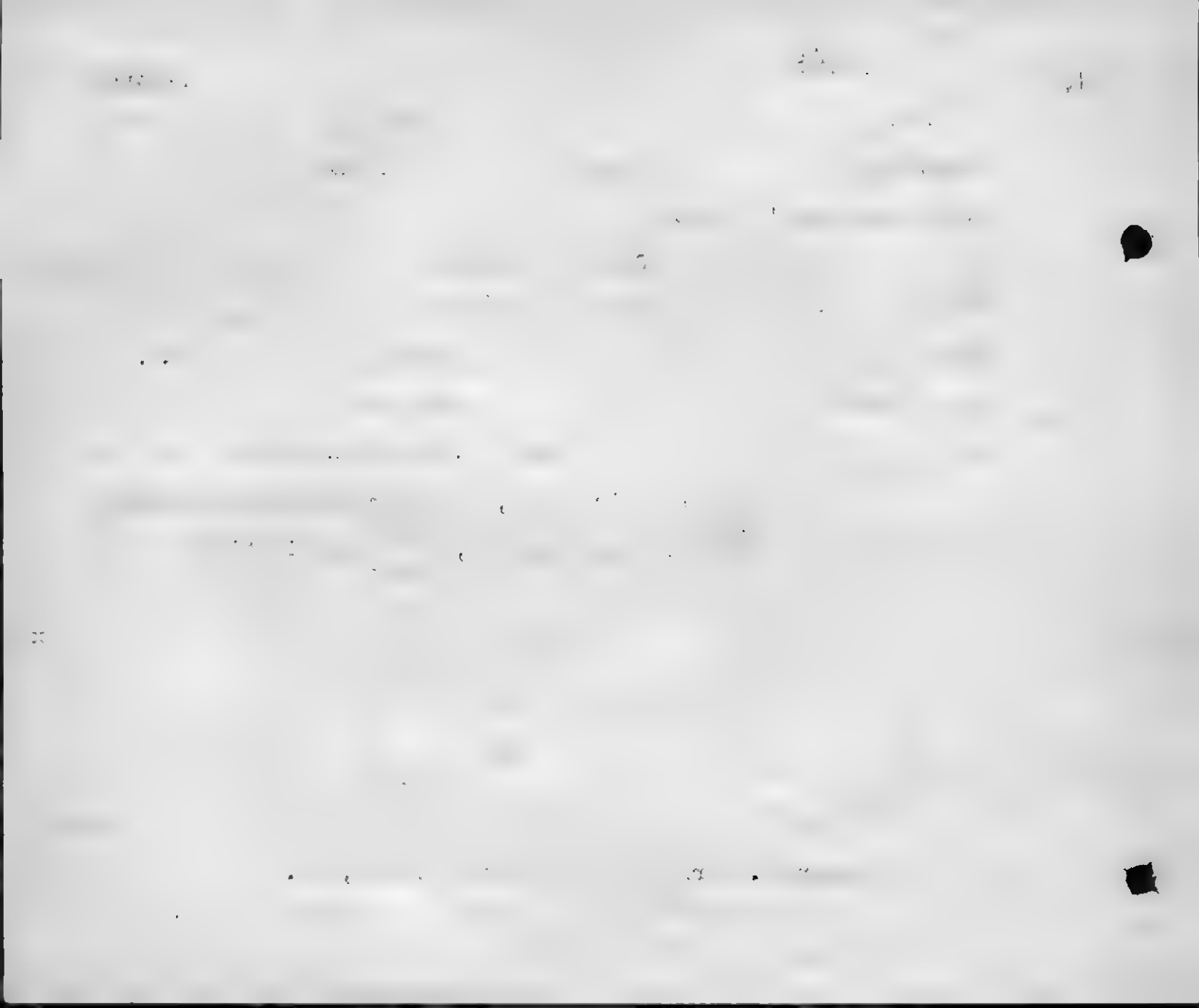
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10309

CERTIFICATE OF DEATH

10304

| | | | | | |
|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Kent | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland | | b. COUNTY
Kent | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chestertown | | c. LENGTH OF STAY IN 1b
12 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Still Pond | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Kent & Queen Anne's Hospital | | d. STREET ADDRESS
- | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Margaret Sarah Nicholson | | 4. DATE OF DEATH
9 18 19 61 | | 5. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| 8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. AGE (In years last birthday)
60 yrs. | | 10. IF UNDER 1 YEAR
Months 60 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Delaware | | 11. BIRTHPLACE (County & State, or foreign country)
U.S. | |
| 13. FATHER'S NAME
Hander Lesage | | 14. MOTHER'S MAIDEN NAME
Jenny Lee | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
no | |
| 16. SOCIAL SECURITY NO.
215-16-3112 | | 17. INFORMANT
Oliver C. Nicholson, Still Pond, Maryland | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiogenic shock, and lower nephron-nephrosi
DUE TO (b) Probable coronary thrombosis
DUE TO (c) Chill, cause unknown, following ligation of left ureter | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20. TIME OF INJURY
Month, Day, Year
19 9 18 | | 20a. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Still Pond, Md. | | 20c. (City or town)
Still Pond, Md. | | 20d. (County)
Still Pond, Md. | |
| 20e. (State)
Md. | | 21. I certify that (I) (this hospital) attended the deceased from 9/18/61 to 9/18/61 that (I) (we) last saw the deceased alive on 9/18/61 and that death occurred 12:25 AM the causes and on the date stated above. | | 22. SIGNATURE
Robert W. Farr | |
| 22a. PHYSICIAN'S NAME (Type)
Robert W. Farr | | 22b. DATE SIGNED
9/18/61 | | 22c. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
9/20/61 | | 23c. NAME OF CEMETERY OR CREMATORY
Sudlersville Cemty | |
| 23d. LOCATION (City, town or county)
Sudlersville, Md. | | 23e. (State)
Md. | | 24. FUNERAL DIRECTOR'S SIGNATURE
Victor N. Kennedy | |
| 24a. ADDRESS
Still Pond, Md. | | 24b. REC'D BY REGISTRAR
SEP 19 61 | | 24c. REGISTRAR'S SIGNATURE
Arthur L. Hines | |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the delay by certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10310 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10305

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Kent MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence of (State and County))
a. STATE Penna b. COUNTY Berks | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
near Rock Hall | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
D Summer home | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Temple | |
| 3. NAME OF DECEASED (Type or print)
Gilbert M. Sawyer | | 4. DATE OF DEATH
Sept. 18, 1961 | |
| 5. SEX
male | | 6. COLOR OR RACE
white | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Nov. 24, 1892 | |
| 9. AGE (In years last birthday)
68 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
Mushroom Broker | |
| 11. BIRTHPLACE (State or foreign country)
New Jersey | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
George Sawyer | | 14. MOTHER'S MAIDEN NAME
Sabra Plum | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
don't know | | 16. SOCIAL SECURITY NO.
.180-01-2280 | |
| 17. INFORMANT
Mrs Gilbert Sawyer, Jr. | | Address
Temple, Pa. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Probable Coronary Thrombosis
DUE TO
Coronary Arteriosclerosis
Deceased was known to have a bad heart. He took nitroglycerin often. was found lying on ground
DUE TO
By a neighbor Mr. R. S. Kent | | INTERVAL BETWEEN ONSET AND DEATH
short | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
no injury | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
no injury | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE
Robert W. Farr | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | DATE SIGNED
9/18/61 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
9/22/61 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Laureldale Cem. | | 22d. LOCATION (City, town, or county) (State)
Berks County, Pa. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. Willis Wells | | ADDRESS
Chestertown, Md. | |
| 24a. REC'D BY REGISTRAR
DATE SEP 22 '61 | | 24b. REGISTRAR'S SIGNATURE
Willis S. Thoma | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

10311 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Kent MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Kent | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rock Hall | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rock Hall | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED
(Type or print)
First Addie Middle L. Last Thompson | | 4. DATE OF DEATH
Month Sept. Day 13 Year 1961 | |
| 5. SEX
Fem | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 15-1879 |
| 9. AGE (In years last birthday)
81 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Thomas Parsons | | 14. MOTHER'S MAIDEN NAME
Eliza Ivons | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<input type="checkbox"/> | | 16. SOCIAL SECURITY NO.
INFORMANT
Jesse Downey--Rock Hall, Maryland | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Terminal bronchopneumonia
334X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Enforced bed care
DUE TO
(c) Feebleness + weakness due to age and secondary
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) recurrent small strokes | | INTERVAL BETWEEN ONSET AND DEATH
10 days
seven years | |
| 18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 19a. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 19b. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 19c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 19d. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1959 to 9-13 , 19 61 , that I last saw the deceased alive on 9/13 , 19 61 , and that death occurred at 3 A.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Chestertown, Md DATE SIGNED 9-14-61
ACTUAL SIGNATURE Robert W. Farr M.D.
PHYSICIAN'S NAME (Type) ROBERT W. FARR | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Sept. 15 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Wesley Chapel | | 22d. LOCATION (City, town, or county) (State)
Rock Hall, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Edgar L. Lane | | 24a. REC'D BY REGISTRAR
DATE SEP 19 '61 | |
| ADDRESS
Church Hill, Md. | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Thomas | |

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10312
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Kent
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Kent | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rock Hall | | c. LENGTH OF STAY IN lb
lifetime | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
(Gratitude Section) | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Blanche Middle Williams Last
4. DATE OF DEATH Sept. 10, 1961
Month Sept. Day 10 Year 19 | | | |
| 5. SEX female | 6. COLOR OR RACE colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan 26, 1893 |
| 9. AGE (In years last birthday) 68 yrs. | | 10. IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
Usa | |
| 13. FATHER'S NAME
Daniel Butler | | 14. MOTHER'S MAIDEN NAME
Frances Thompson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT
Mrs. Wm. Lee - Rock Hall, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Edema
444X DUE TO Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Sept 1 19 61 , to Sept 10 19 61 , that (I) (we) last saw the deceased alive on Sept 9 19 61 , and that death occurred at 2 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Norbert C. Nitsch | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
Norbert C. Nitsch | | 22d. ADDRESS
Rock Hall, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
9 9/12/61 | 23c. NAME OF CEMETERY OR CREMATORY
Sharptown Cemetery | 23d. LOCATION (City, town, or county) (State)
near - Rock Hall, Md. |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Benneth Waller | | 25a. REC'D BY REGISTRAR
SEP 13 '61 | |
| ADDRESS
Chestertown, Md. | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Kraus | |

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